

2003-D Special Session

Summary of Legislation Passed



*Compiled and Edited by
Office of the Senate Secretary*

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HB 3-D — Act Relating to Corrections

by Rep. Kyle and others (SB 4-D by Senator Crist)

This bill (Chapter 2003-417, L.O.F.) relates to the Department of Corrections, and provides moneys for the operations and construction of new prison beds to meet the increased prison population projected by the Criminal Justice Estimating Conference (CJEC) on July 9, 2003.

This bill directs the Executive Office of the Governor to notify the CJEC if the inmate population exceeds the projections of the July 9, 2003 Estimating Conference by 1 percent for two consecutive months or 2 percent for any one month for the purpose of convening the conference to revise the estimates.

The bill provides the Department of Corrections with a mechanism to establish additional positions and spending authority sufficient to accommodate the estimated increase in the inmate population, with the approval of the Legislative Budget Commission.

The bill allows the Governor to initiate prison bed construction to meet the demand of any revised estimates adopted by the CJEC. These actions are subject to review by the Legislative Budget Commission.

This bill increases the Department of Corrections appropriations. It provides:

- \$22.1 million to fund housing and inmate variable expenses in the Department of Corrections for the operations of new prison beds.
- \$5.1 million to fund the operating costs of reopening the Hendry Correctional Institution.
- \$3 million to fund operating costs of reopening the South Florida Reception Center.
- \$4.8 million for the construction of fourteen 131-bed, open-bay dormitories at various existing institutions around the state.
- \$1.3 million for the renovations and repairs at the Hendry Correctional Institution.
- \$27.6 million to begin the construction of a new 1,380-bed prison annex at the Santa Rosa correctional institution.
- \$2 million is provided to start the permitting and planning for a new 1,380-bed prison annex at the Washington Correctional Institution.

The bill provides that if the Department of Corrections certifies the need for expediency, the competitive bid and procurement requirements of ss. 287.057(5)(a), 255.0525, 255.29(2) and (3), 287.055(3), (4), (5), and (9), and 287.057(1)(a), F. S., are waived for the purposes of three of the fixed capital outlay appropriations contained in section 3 of the bill.

This bill allows the Department of Corrections to enter into a multi-year contract with only the first year appropriation for the construction of the Santa Rosa Correctional Institution annex.

The bill provides for the reversion of \$8,621,040 from the Department of Corrections Grants and Donations Trust Fund appropriation provided in Specific Appropriation 660A of the Conference Report for SB 2-A.

This bill provides that if any law that is amended by this act was also amended by a law enacted at the prior 2003 legislative sessions, such laws must be construed as if they had been enacted during the same session of the legislature, and full effect, if possible, should be given to each.

These provisions were approved by the Governor and took effect August 14, 2003.

Vote: Senate 37-0; House 90-22

CS/SB 2-D — Medical Incidents

by Health, Aging, and Long-Term Care Committee and Senators Jones, King, Clary, Diaz de la Portilla, Lawson, Lee, Peaden, Pruitt, Saunders, Sebesta, and Smith

The bill (Chapter 2003-416, L.O.F.) amends the law affecting medical incidents in the areas of patient safety and improved quality of health care, insurance regulation, litigation, and the Florida Birth-Related Neurological Injury Compensation Association (NICA). Specifically, this bill makes changes as follows:

Patient Safety and Improved Quality of Health Care

Regulations regarding health care facilities

- Requires health care facilities and practitioners to inform patients or the patients' representatives of adverse medical incidents that result in harm to the patient.
- Requires patient safety plans, including appointment of patient safety officers and committees, in hospitals, ambulatory surgical centers, and mobile surgical facilities.
- Requires hospitals, ambulatory surgical centers, and mobile surgical facilities to report the name and judgments entered against health care practitioners for whom they assume liability.
- Deletes the duplicative reporting requirement under s. 395.0197, F.S., for hospitals, ambulatory surgical centers, and mobile surgical facilities to notify the Agency for Health Care Administration (AHCA) within 1 business day of the occurrence of certain adverse incidents and repeals the related Public Records Law exemption in s. 395.0198, F.S.
- Establishes a privilege from discovery or introduction into evidence in any civil or administrative action for patient safety data. The terms "patient safety data" and "patient safety organization" are defined. A patient safety organization must promptly remove all patient-identifying information after receipt of a complete patient safety data report unless such organization is otherwise permitted by state or federal law to maintain such information.
- Makes activities done pursuant to quality improvement review, evaluation, and planning in a state-licensed health care facility immune from civil liability.

Licensure requirements and regulations regarding health care professionals

- Requires medical schools, nursing schools, and allied health training programs to include instruction in patient safety.
- Revises practitioner profile elements and reporting requirements for physicians.
- Revises reporting requirements concerning professional liability claims against a licensed health care practitioner alleging medical malpractice.

- Requires that the 2 hours of continuing education in prevention of medical errors required for medical and osteopathic physicians and physician assistants include information on misdiagnosed conditions.
- Requires the suspension of the license of a medical or osteopathic physician when judgments, arbitration awards, or settlement amounts have not been paid pursuant to statutory requirements.
- Revises financial responsibility requirements for medical and osteopathic physicians.
- Prohibits medical and osteopathic physicians from using financial responsibility coverage amounts to cover defense litigation costs or attorney fees in a medical malpractice action.
- Removes the limitation of no more than a 10 percent licensure fee increase from the previous biennium for health care practitioners.

State agency duties

- Revises requirements for the determination of conclusions of law and findings of fact by the Department of Health (DOH) or boards for standard of care violations involving practitioners under the department's or boards' regulatory jurisdiction.
- Revises assessment of costs associated with a disciplinary action of a health care practitioner.
- Requires the Division of Administrative Hearings (DOAH) to designate at least two administrative law judges with certain qualifications to preside over actions involving health care practitioner discipline.
- Revises the rights of a respondent licensee in disciplinary cases to affirmatively require election of a formal hearing within 45 days after service of the administrative complaint and eliminates the ability to raise an issue of disputed fact during an informal hearing.
- Requires AHCA to compare copies of complaints alleging negligence by the hospital with adverse incident reporting and licensure requirements and to proceed with disciplinary actions against such hospitals for noncompliance.
- Requires reports to be prepared concerning health care professionals and claims against those licensees.
- Establishes emergency procedures for the discipline of medical physicians, osteopathic physicians, and podiatric physicians who have reported three closed malpractice claims within a 60-month period to the Office of Insurance Regulation (OIR).
- Authorizes DOH, notwithstanding the 6-year limitation on the investigation or filing of an administrative complaint, to investigate professional liability actions reported in the previous 6 years, rather than 10 years, for any paid claim exceeding \$50,000.
- Revises requirements for alternative disciplinary procedures including mediation and citation offenses.
- Gives DOH additional subpoena power in prosecuting disciplinary cases.
- Revises the monetary thresholds for what constitutes gross or repeated malpractice for disciplinary purposes.
- Requires DOH to study the current health care practitioner disciplinary process and report by January 1, 2004.

Agency studies

- Requires AHCA, in consultation with DOH and certain existing patient safety centers, to complete a study on the implementation requirements of establishing a statewide Patient Safety Authority. The proposed duties of the Patient Safety Authority are listed and the agency must complete its study and issue a report to the Legislature by February 1, 2004.
- Requires AHCA to conduct or contract for a study to determine if it is feasible to provide information to the public that will help them make better health care decisions regarding their choice of a hospital, based on that facility's patient safety and quality performance.
- Requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) and the Auditor General to conduct a study of practitioner disciplinary cases and closed claims.

Medical Malpractice Insurance

Medical malpractice insurance

- Requires a rate freeze and mandatory rate filing to reflect the savings of the bill. Rates approved on or before July 1, 2003 for medical malpractice insurance remain in effect until the effective date of the new rate filing required by the act. Insurers must make a rate filing effective no later than January 1, 2004, to reflect the savings of the act, using the presumed factor established by OIR, or using a different factor if the insurer contends that the presumed factor results in a rate that is excessive, inadequate, or unfairly discriminatory, subject to prior approval by OIR. The new rate would apply to policies issued or renewed on or after the effective date of the act, requiring insurers to provide a refund for policies issued between the effective date of the act and the effective date of the rate filing.
- Requires medical malpractice insurers to notify insureds at least 60 days prior to the effective date of a rate increase and at least 90 days prior to cancellation or non-renewal.
- Provides that medical malpractice rate filings disapproved by OIR may not be submitted to an arbitration panel, but would be subject to administrative review pursuant to ch. 120, F.S.
- Requires medical malpractice insurers to notify policyholders upon making a rate filing that would have a statewide average increase of 25 percent or greater.
- Requires that medical malpractice insurers make a rate filing at least once annually, sworn to by at least two executive officers.
- Revises the rating standards for medical malpractice insurance to prohibit the inclusion of payments made by insurers for bad faith or punitive damages in the insurer's rate base. Such payments shall not be used to justify a rate or rate change.
- Requires OPAAGA to study the feasibility and merits of authorizing the Office of the Public Counsel to represent the public in medical malpractice rate matters.
- Revises the closed claim reporting requirements of s. 627.912, F.S., to: (1) require reporting by all types of insurance and self-insurance entities, including specified health

care practitioners and facilities for claims not otherwise reported by an insurer; (2) include reports of claims resulting in nonpayment; (3) include professional license numbers; (4) provide for electronic access to DOH for all closed claim data and otherwise delete separate reporting to DOH; (5) increase penalties for nonreporting; (6) provide that violations by health care providers of reporting requirements constitutes a violation of their practice act; (7) require OIR to prepare an annual report analyzing the closed claim reports, financial reports submitted by insurers, approved rate filings, and loss trends; (8) authorize the Financial Services Commission to adopt rules to require the reporting of data on open claims and reserves; and (9) maintain current law for provisions that apply to professional liability for attorneys so that the bill is limited to the single subject of “medical incidents.”

- Authorizes a group of 10 or more health care providers to establish a commercial self-insurance fund for providing medical malpractice coverage.
- Eliminates an existing prohibition against creating new medical malpractice self-insurance funds and authorizes the Financial Services Commission to adopt rules relating to such funds.

Medical Malpractice Liability and Litigation

Presuit process

- Redefines “health care provider” for those subject to presuit procedural requirements.
- Revises and enhances statutory criteria for who may be qualified to offer presuit corroborating medical expert opinions and expert witness testimony.
- Makes presuit medical expert opinions discoverable.
- Prohibits contingency fee agreements for expert witnesses.
- Requires attorneys to certify that expert witnesses are not guilty of fraud or perjury.
- Requires a claimant to execute a medical information release to authorize a defendant to take unsworn statements from a claimant’s physician and prescribes the conditions and scope for the taking of these statements.
- Specifies potential sanctions if parties fail to cooperate with presuit investigations.
- Requires DOH to study and report by December 31, 2003, on whether medical review panels should be created for use during the presuit process. If DOH recommends that such panels should be created, then the report must include draft legislation to implement that recommendation.

Suit

- Requires claimants to provide AHCA with a copy of a complaint against a hospital or ambulatory surgical center licensed under ch. 395, F.S.
- Requires settlement forms to include boilerplate language regarding the implication of a decision to settle.
- Requires specific itemization of damages, as part of a verdict for medical malpractice actions, to include break-out for future losses.

Caps on noneconomic damages in an action for personal injury or wrongful death arising from medical negligence by a practitioner or nonpractitioner

- For an injury other than a permanent vegetative state or death, noneconomic damages are capped at \$500,000 from each *practitioner defendant* and \$750,000 from a *nonpractitioner defendant*. However, no more than \$1 million and \$1.5 million can be recovered from all practitioner defendants and all nonpractitioner defendants, respectively, regardless of the number of claimants. Alternatively, the \$500,000 cap and \$750,000 cap can be “pierced” to allow an injured patient to recover up to \$1 million and \$1.5 million aggregated from all *practitioner defendants* and all *nonpractitioner defendants*, respectively, if the injury qualifies as a *catastrophic injury* and manifest injustice would occur if the cap was not pierced.
- For an injury that is a permanent vegetative state or death, noneconomic damages are capped at \$1 million and \$1.5 million from *practitioner defendants* and *nonpractitioner defendants*, respectively, regardless of the number of claimants.
- For any type of injury resulting when a practitioner provides *emergency services* in a hospital or *life support services* including transportation, provided there is no pre-existing health care patient-practitioner relationship, noneconomic damages are capped at \$150,000 per claimant but cannot exceed \$300,000, regardless of the number of claimants or practitioner defendants. This cap only applies to injuries *prior to the patient being stabilized*.
- For any type of injury resulting when a *nonpractitioner provides emergency services in a hospital or prehospital emergency treatment pursuant to statutory obligations*, provided there is no pre-existing health care patient-practitioner relationship, noneconomic damages are capped at \$750,000 per claimant from all nonpractitioner defendants but cannot exceed \$1.5 million, regardless of the number of claimants or nonpractitioner defendants.
- Allows for setoff against noneconomic damages exceeding the statutory caps, provided a reduction is made first for comparative fault.
- Requires reduction of any award for noneconomic damages by any settlement amount received in order to preclude recovery in excess of the statutory cap.
- Clarifies that the caps on noneconomic damages applicable in medical negligence trials are applicable to trials that take place following a defendant’s refusal to accept a claimant’s offer of voluntary binding arbitration.
- Caps recovery of noneconomic damages in voluntary binding medical negligence arbitration involving wrongful death.

Bad faith actions against insurers

- Provides that a professional liability insurer, for insuring medical negligence, may not be held to have acted in bad faith for failure to timely pay policy limits if it tenders its policy limits and meets other reasonable conditions of settlement before the earlier of two events: the 210th day after service of the complaint or the 60th day after the conclusion of

the deposition of parties and expert witnesses, the initial disclosure of witnesses and production of documents, and required mediation.

- Provides that the failure to tender policy limits is not presumptive of an insurer acting in bad faith and provides factors to be considered by the trier of fact in determining whether an insurer has acted in bad faith.
- Provides that when an insurer tenders policy limits and such tender is accepted by the claimant, the insurer is entitled to a release of its insured.

Immunity

- Provides immunity from injunctive or civil relief against any licensed facility or its board, board members, or staff arising out of or relating to carrying out activities relating to staff membership or clinical privileges at a hospital, ambulatory surgical center, or mobile surgical facility, absent intentional fraud.
- Provides immunity from vicarious liability to insurers, prepaid limited health service organizations, and health maintenance organizations for the negligent acts of their employees or persons with whom they contract.
- Revises the circumstances under which immunity from civil liability under the Good Samaritan Act applies, by extending the immunity to any health care provider providing emergency services pursuant to obligations imposed by federal and state statutes and revises the definition of “reckless disregard” for purposes of extending such immunity; and by extending the immunity to any health care practitioner who is in a hospital and who voluntarily provides immediate emergency care or treatment to a nonpatient of his or hers.
- Extends sovereign immunity to health care practitioners who have contractually agreed to act as agents of a state university board of trustees to provide medical services to a student-athlete for participation in or as a result of intercollegiate athletics.
- Provides immunity for physicians performing high school examinations for student athletes by revising the requirements for the Florida High School Activities Association by-laws for participation in interscholastic athletics to require that an evaluation and history form incorporate recommendations of the American Heart Association for participation cardiovascular screening and removing standards by which certification is conducted.

Florida Birth-Related Neurological Injury Compensation Association

Florida Birth-Related Neurological Injury Compensation Association Program

- Adds infants who receive a NICA award to the Children’s Medical Services (CMS) program, requires reimbursement to CMS for services, and makes the reimbursement eligible for federal matching funds.
- Clarifies that, if a claimant accepts an award from NICA, no civil action may be brought, and an award from NICA may not be made or paid if the claimant recovers in a civil action.

- Provides that medical records and related information in a claim are to be filed with NICA, rather than with DOAH, and are to be included within a current public records exemption.
- Authorizes an administrative law judge to bifurcate NICA proceedings.
- Limits NICA claimants liability for attorneys fees.
- Creates a \$10,000 death benefit for an infant and strikes requirements to pay funeral expenses up to \$1,500.
- Permits a hospital in a county of more than 1.1 million gross population as of January 1, 2003, to pay the NICA fee for participating physicians and midwives.
- Requires OPPAGA to study the eligibility requirements for a birth to be covered under the NICA and report to the Legislature by January 1, 2004.

These provisions were approved by the Governor and take effect September 15, 2003, except as otherwise provided in the bill.

Vote: Senate 32-4; House 87-2